NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

April 10, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016

Via Regulations.gov

To whom it may concern:

The following comments on the proposed 2025 Marketplace Integrity and Affordability Proposed Rule (Proposed Rule), as published in the Federal Register on March 19, 2025, are submitted on behalf of the National Association of Insurance Commissioners (NAIC) which represents the chief insurance regulators in the 50 states, the District of Columbia, and 5 U.S. Territories.

Rule Timing Relative to Plan Year 2026

State regulators wish to express great concern about the timing of the Proposed Rule given that it proposes myriad changes to plan design and marketplace operations for plan year (PY) 2026. NAIC urges CMS to reconsider the timing of the implementation of at least some provisions of the Proposed Rule due to the additional burdens they place on regulators, marketplaces, health insurers, and consumers for PY 2026.

With enhanced premium tax credits set to expire at the end of 2025 and potential Congressional action on health programs like Medicaid, significant uncertainty already surrounds the 2026 markets. Several provisions proposed in this rule only add to that uncertainty. At this point in the year, health insurers have already completed their PY 2026 plan designs and must soon submit rates to their state regulators. Insurers need to know the rules under which they will be operating to fully weigh their options and develop appropriate plans and rates. They will not know the rules until this proposal is finalized, so we expect rate increases to result from the uncertainty generated by these late rule changes, as well as uncertainty over enhanced premium tax credits. To implement these changes for PY 2026 will present significant challenges and could add to consumer and federal costs.

The changes such as increasing consumers' maximum out-of-pocket costs, allowing issuers to design plans with reduced actuarial values, and adding a $5 monthly penalty for consumers who do not actively re-enroll in coverage could encourage consumers to leave the market. The impact of these changes could result in fewer individuals enrolled in coverage in 2026 than in 2025, with those who are youngest and healthiest being most likely to drop or not pursue coverage in 2026. Resulting

coverage losses would compromise the integrity and health of the risk pool, discourage carrier participation, lead to higher premiums, and destabilize state insurance markets. The possible extent of these changes and their impact on individual market risk pools needs to be known before plans and rates can be established for PY 2026.

The Proposed Rule would place new requirements on consumers, as well, such as additional paperwork submissions and the new $5 premium for some. It is critical that consumers understand these requirements before they go into effect. The required implementation of these changes for PY 2026 will present substantial consumer education challenges, especially in light of the substantial reductions in Navigator funding and the proposed open enrollment period reduction.

Finally, the additional administrative and systems changes that would be required of State-Based Marketplaces (SBMs) under this Proposed Rule will be burdensome and costly if they need to be implemented for PY 2026.

Given the concerns expressed above, we encourage CMS to move the implementation date of the new rules to PY 2027. If any changes are to be effective for PY 2026, the final rule must be published as soon as possible, preferably within a month of the comment deadline.

Comment Deadline

As we have noted with respect to past proposed rules, a 30-day comment period is too brief for a rule that proposes these many changes to complex policies applicable to health insurance issuers, regulators, marketplaces, and consumers. We urge CMS to provide a longer comment period in the future to allow stakeholders an adequate opportunity to analyze the proposed changes and formulate useful comments.

State Flexibility on the Open Enrollment Period

The Proposed Rule would require all states to run their Annual Open Enrollment period (OEP) exclusively from November 1 to December 15, with coverage beginning January 1 of the following year. There are valid operational and consumer protection reasons for states setting an OEP that varies from the Federal dates, such as providing additional time for consumers to make informed decisions about their coverage and allowing for flexibility in plans' start dates.

NAIC encourages CMS to allow SBMs to set OEP dates that best meet the needs of their consumers and markets, beginning before November 1 if the state chooses, or ending after December 15. Indeed, many SBMs have maintained consistent OEP dates that consumers and stakeholders have come to know and expect, providing market stability. Regulators do not believe that requiring SBMs to abandon existing consistency within their states to align with federal OEP dates provides any tangible benefits for consumers. Extending the Open Enrollment Period into January provides consumers with more time to choose a plan and provides the opportunity for plan switching for a brief period after the benefit year begins. A majority of SBMs have used their authority to extend open enrollment beyond December 15 but not all have chosen to do so. Some have chosen to extend later in December, but not into January. To avoid disruption in these states and preserve state flexibility, we urge this change to be made optional for SBMs.

State Flexibility on Other Proposals

A number of other provisions in the Proposed Rule would limit the ability of SBMs to make their own choices and require them to adopt changes to their operations for PY 2026. The Proposed Rule would require SBMs to take action based on a single fail-to-reconcile notice; end extensions of the deadline for consumers to file paperwork to resolve income inconsistencies; stop the practice of reenrolling consumers into plans that save them money; and verify a greater share of special enrollment periods. The Proposed Rule also includes new limitations on the ability of states to establish their Essential Health Benefits (EHB), which impacted states will not have enough time to comply with if this provision goes into effect for PY 2026.

State regulators object to these limits to state authority. We urge CMS to maintain state flexibility in these areas permanently. If state flexibility is removed in these areas, states should be given sufficient time to make the necessary changes.

Auto-Reenrollment

The Proposed Rule would require two substantive changes to the auto-reenrollment process. It would establish a $5 monthly premium for consumers who are automatically re-enrolled and previously qualified for a monthly premium of $0 until the consumer actively confirms eligibility and enrollment. It also would remove the option for Marketplaces to re-enroll consumers who had selected a bronze plan into a silver plan, when that silver plan costs them the same or less and includes the same provider network. Both of these changes would be most burdensome on those who can afford it the least.

State regulators share the goal of ensuring that only eligible consumers receive premium tax credits. At the same time, we do not believe Marketplaces should establish unnecessary barriers to enrollment or continued enrollment. Current practices seek to ensure continued eligibility: consumers are required to report changes in their eligibility information to Marketplaces; the auto-reenrollment process includes checks of income and other eligibility data; and the reconciliation requirement at tax filing serves as a backstop to recoup improper APTCs. Adding the $5 premium as a barrier to continued enrollment would help to encourage some enrollees to update their information. However, it is also likely to lead some eligible enrollees to lose coverage, as a state entity would be required to withhold a federal tax benefit from its consumers, potentially without the consumer's awareness. We urge CMS to make this policy optional for SBMs, at the very least.

Re-enrolling consumers with bronze plans into silver can be very beneficial for consumers who qualify for cost-sharing reductions. State regulators recognize that some consumers lack understanding of the elements of health insurance cost-sharing, such as co-pays and deductibles. The concept of actuarial value is even less well understood, let alone that cost-sharing reductions are available only in silver plans. Consumers may enroll in bronze plans because they are unaware of the benefits of silver plans, invested too little time in choosing a plan and made their plan choice based exclusively on premium without fully understanding their total financial exposure when deductibles and cost-sharing are included, or received incomplete advice from a producer or assister. Nonetheless, some consumers may choose bronze plans knowing the benefits they are forgoing—current policy allows them to change back to a bronze plan if they are auto-reenrolled into silver. We support giving Marketplaces the option of retaining this feature of the reenrollment hierarchies so that SBMs can choose whether the revised hierarchy is in the best interests of consumers and insurance markets in their states.

Special Enrollment Period for Consumers with Low Income

The Proposed Rule would end the monthly Special Enrollment Period for consumers eligible for APTC with income below 150% of the federal poverty level. As we pointed out in our comments when the policy was codified in the 2022 Notice of Benefit and Payment Parameters, the ongoing SEP creates some risk of adverse selection and increased premiums. However, we supported the option for SBMs to implement the policy and we continue to believe SBMs should have the choice.

We also urge CMS to take additional steps to combat unauthorized enrollments or plan transfers. We do not believe that the under 150% SEP is a major contributor to such improper practices – it was not a major problem for SBMs, which seems to indicate that FFM procedures are the key issue. CMS has already implemented system changes to limit unauthorized enrollments and has taken a more timely approach to suspending and terminating producers suspected of improper practices. We urge continued and expanded efforts in these areas to address vulnerabilities in the federal marketplaces, regardless of the final policy on special enrollments for low-income consumers.

Co-Pay Accumulator Enforcement

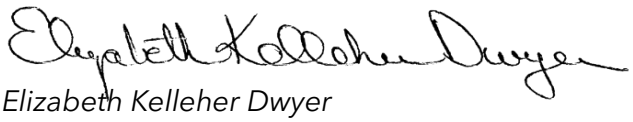
State insurance regulators urge CMS to move forward with rulemaking to clarify whether health insurers may operate co-pay accumulator programs and disregard the value of co-pay assistance provided by drug manufacturers or other third parties. After its co-pay accumulator rule was invalidated by judicial action in 2023, CMS has chosen not to enforce the previous rule. Some states have chosen to do so, but the lack of enforcement or clarity from federal regulators has introduced challenges. We ask CMS to publish a new rule on this topic as soon as possible and we would welcome the opportunity to share more state perspectives on enforcement.

Thank you for your consideration of these comments. We again strongly urge you to continue the historical position of state deference as you look to finalize this Proposed Rule. The flexibility afforded states in developing their Marketplaces has led to record enrollment across many of the SBMs and states have continued to develop innovative programs for the benefit of their constituencies. We welcome continued collaboration with CMS on our shared goals of healthy markets and consumer protection.

Sincerely,

Jon Godfread
NAIC President
Commissioner
North Dakota Insurance Department

Scott White
NAIC President-Elect
Commissioner
Virginia Bureau of Insurance



Elizabeth Kelleher Dwyer
NAIC Vice President
Director
Rhode Island Department of Business Regulation

Jon Pike
NAIC Secretary-Treasurer
Commissioner
Utah Insurance Department