State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF THE COMMISSIONER
PO BOX 325
TRENTON, NJ 08625-0325

TEL (609) 633-7667

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

JUSTIN ZIMMERMAN
Commissioner

April 11, 2025

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–9888–P
P.O. Box 8016 Baltimore, MD 21244-8016
Via Regulations.gov

Re: HHS Marketplace Integrity and Affordability rule proposal – File Code CMS-9884-P

To Whom It May Concern:

The following comments on the proposed Marketplace Integrity and Affordability rule proposal (Notice), as published in the Federal Register on March 19, 2025, are submitted on behalf of the New Jersey Department of Banking and Insurance (the Department). By way of background, through its Division of Insurance, the Department regulates the health insurance industry in New Jersey, including performing rate review for the individual market, market conduct examinations, and other regulatory functions. In addition, the Department operates "Get Covered New Jersey," which is New Jersey's State-based Exchange (SBE) and a division within the Department. New Jersey transitioned to a SBE beginning plan year 2021.

New Jersey also implemented P.L.2020, c.61 on January 1, 2021, to create funding for state subsidies, in addition to advance premium tax credits, for qualified individuals to further improve affordability and demonstrate the value of operating a state Marketplace.

Further, P.L.2018, c.24, created the New Jersey Health Insurance Premium Security Program. Under this state law, the Department applied for and received approval for federal funds for a reinsurance program through a 1332 Innovation Waiver. Beginning in 2019, through the creation of the reinsurance program, New Jersey's individual market rates are approximately 15% lower than they otherwise would be. The reinsurance program was approved by the Centers for Medicare & Medicaid Services for an initial five-year period and was extended for an additional five-year period, through 2028.

At the end of this year's Open Enrollment Period (OEP), Get Covered New Jersey – the State's Official Health Insurance Marketplace – hit an all-time record enrollment with more than a half a million New Jerseyans signed up for 2025 health coverage. Enrollment on the marketplace has more than doubled since New Jersey took over operations from the federal government and launched Get Covered New Jersey in 2020. This year a total of 513,217 New Jersey residents signed up for health insurance under Get Covered New Jersey during the OEP from November 1, 2024 through January 31, 2025. This includes 197,876 new or existing consumers who actively selected a plan. This year's record-breaking sign-ups represent nearly a 30% increase compared to last year's OEP when 397,942 residents signed up for 2024 health coverage. Overall, there has been a 108% increase in enrollment since the State launched Get Covered New Jersey.

Congress's stated purpose in enacting the Patient Protection and Affordable Care Act (ACA) created marketplaces was to expand access to affordable coverage options. The Department supports this important purpose, which has increased access to preventive services and other critical health care for hundreds of thousands of New Jersey residents. Generally, many of the policies identified in the Notice are aimed at problems not found in the New Jersey insurance market or our State-based Exchange and would disrupt the Department's ongoing work to provide quality, affordable coverage to eligible New Jerseyans. The Department believes it is critical to have flexibility to innovate and customize Exchange operations to the State's needs, which was a key factor in establishing Get Covered New Jersey. The Department believes that it is important to allow Exchanges flexibility in the design of their operations since the scale, characteristics, and dynamics of a given Exchange are unique to each State, its residents and insurance market. The proposal would limit state autonomy in favor of federal decision making. This imposes burdens on states with unreasonable timelines to implement these policies. The proposal abruptly reverses policies and practices relied on for years in New Jersey that have created our current strong insurance market, including a better risk pool, which have ultimately benefited New Jersey consumers.

Creating standards among the SBEs has merit, but policies that reduce the State flexibility needed to address local market issues should be carefully considered and narrowly crafted. Therefore, the Department cautions that, where proposed policies create new administrative requirements without state data confirming the need to address the issue within that state's market, there may be unintended consequences and unnecessary costs. Accordingly, such policies should be flexible and implemented with sufficient lead time and with consideration for the operational challenges they may create.

Protecting the individual market risk pool is important, which is why the Department and the State implemented numerous state policies since 2018 to successfully create a stronger risk pool in the individual market. The result has been a doubling of the number of carriers offering health plans on the exchange as well as doubling enrollment. Impacts of numerous major proposals on the risk pool is difficult to quantify, particularly in less than 30 days, and should not come at the cost of dramatically increasing uninsured rates. Therefore, the Department would encourage the U.S.

Department of Health and Human Services (HHS), to delay these proposals until there is time for further review, comment, and consideration of additional state feedback.

The Department appreciates your consideration of the following comments.

Annual Open Enrollment Period (OEP)

HHS proposes to shorten the Open Enrollment Period (OEP) to November 1 through December 15 for plan year 2026 and beyond. HHS cites adverse selection, consumer confusion, and exchange/assister/broker burden as the basis for reducing the OEP, which it believes outweigh the benefits of allowing for needed plan switching early in the year for those consumers who receive a surprisingly high January bill, and from increased enrollment from younger consumers who tend to enroll later (Notice page 12978).

Department Comment: This is a surprising break from historic deference to state flexibility in operating state insurance markets, without justification for the need to constrain state authority. The Department has invested a significant amount of time and state funds into creating a now widely known three-month OEP in New Jersey that has existed since the inception of New Jersey's State-based Exchange (OE 2021). This period was statutorily established prior to the exchange beginning operations. N.J.S.A. 17B:27A-6.1. It allows for the exchange and its partners to reasonably expand OEP work across a reasonable timeframe, outside of the holiday period, when consumers generally feel more financially stressed. New Jesey has not found that the extended period has had negative effects on is markets. On the contrary, allowing residents to enroll over a three-month OEP has improved access to quality, affordable health coverage for New Jersey residents; contributed to an increase in enrollment; and improved the risk pool in the individual market.

The ACA statute provides that it shall not be construed to preempt any State law that does not prevent the application of the provisions of the ACA. 42 U.S.C. 18041. New Jersey encourages HHS to continue to allow states to have the flexibility to operate their own OEP because it does not prevent the application of any of the ACA's provisions and for the following additional reasons.

1. Significant changes are expected for plan year 2026. HHS mentions that only a small percentage of enrollees (470,000 at the FFM; Notice page 12978) took the extra time they were given (through January 15) to switch plans after getting the January premium bill post-December 15. It would be reasonable to continue to accommodate this half a million enrollees who needed extra time, as well as the similarly situated New Jersey enrollees, and enrollees of other states. However, given the significant changes HHS expects to make to enrollments for plan year 2026, extra time will be even more critical during this upcoming year by consumers and their brokers/assisters to carefully review, understand and update enrollments. Consumer confusion are anticipated to be at an all-time high due to multiple changes stemming from this proposal. Therefore, it is imperative that Exchanges provide consumers a reasonable amount of time to adjust enrollments in plan year 2026. Due to the significant changes in this proposal, the Department believes

flexibility for State-based Exchanges to determine their OEPs is imperative. If this proposal is not withdrawn, any change in OEP time periods should be delayed until plan year 2027, at a minimum.

2. Adverse Selection is not a factor for New Jersey. The Department does not find that New Jersey consumers enrolling in January instead of December negatively effects New Jersey health insurance markets due to adverse selection. In fact, if this proposal is adopted, the impact of this proposal to drastically shorten the OEP in New Jersey would negatively impact the risk pool. Half of New Jersey's active enrollments occurred after December 15 during the last OEP. Obviously, enrollment by half of the total market could not be considered to be causing adverse selection. It is quite the opposite, as this half of the market is bolstering the risk pool. The New Jersey individual market risk pool remains strong with an OEP that extends through January.
3. Consumer confusion around OEP is not a factor for New Jersey consumers. As stated above, the Department has invested significantly, over $75 million dollars of state funds, in establishing a well-known state OEP in New Jersey. A longer OEP does not cause consumer confusion for New Jersey residents wanting to enroll in coverage. On the contrary, an abrupt change to a shorter period, as proposed, would cause drastic confusion, have negative consequences on consumers, and would negatively impact the risk pool.
4. Additional burden on Exchange/Assisters/Brokers or Issuers from a longer OEP does not apply in New Jersey. The Department is greatly concerned that compressing all of the State-based Exchange's OEP activities into half the time would be a burden on New Jersey's exchange operations, as well as that of its assisters and brokers. New Jersey has spent the past five years organizing its OEP workload over three months, allowing for effective consumer assistance and enrollment processes. Such an extreme shift in how the eligibility and enrollment work would be completed in New Jersey would be disruptive, and hectic for brokers and assisters. It would be an unnecessary strain on operations and consumer assistance workloads to quickly try to pivot to prepare for such a shift in operations (systems, communication strategies, marketing, service center operations, and staffing). Brokers will have insufficient time to renew all of their consumers, which could lead to fewer application updates. This negatively impacts consumers' ability to get the right amount of Advance Premium Tax Credit (APTC) and the best enrollment for their situations.
5. There would be significant exchange costs to change to a new OEP. New Jerseyans now count on the November through January OEP to complete their enrollment updates. Cutting that period in half, or altering the OEP dates, would be difficult to communicate to consumers, would require substantial mobilization of partners, and would have significant costs. It would be a tremendous effort to now educate New Jerseyans that the OEP that they have grown used to would be ending in the middle of the holiday season on December 15.

The Department has long supported the position that states should be afforded the maximum flexibility possible to implement SBEs in the ways that make sense to the particularized characteristics and needs of each state. The Department believes that a federally-mandated limit on states that were previously afforded flexibility, to the possible new, federally-prescribed OEP is contrary to ensuring consumers have a full opportunity to review plans and enroll in the coverage option that is best suited to their individual needs, and impinges on the ability of states to design their exchanges in the manner best suited to their circumstances and the needs of their residents.

Change Definition to Lawfully Present

HHS is proposing to remove Deferred Action on Childhood Arrivals (DACA) recipients from the definition of lawfully present that is used for exchange coverage eligibility.

Department Comment: The Department does not support this change in HHS policy. While the Department of Homeland Security's (DHS) interpretation of the DACA rules have changed over time, DHS's final rule on DACA reiterated the agency's view that a non-citizen who has been granted deferred action is deemed "lawfully present" for purposes of Social Security benefits.

CMS reconsidered its Marketplace and BHP policies in light of the DHS 2022 rule and, in 2024, the agency finalized a rule that would no longer treat DACA recipients differently than other people granted deferred action. Not only does this ensure equitable treatment across this population, the 2024 final rule more properly aligns with the goals of the ACA to reduce the numbers of uninsured and improve access to affordable health coverage.

The Department disagrees with the proposed rule regarding the impact of DACA recipients on the risk pool. The Department believes removing DACA recipients would remove from the risk pool a population that is healthier, on average, than the general population.

In addition, the abrupt proposed change will place considerable burdens on Get Covered New Jersey, requiring New Jersey to reverse current processes and change systems, mid-year, to terminate coverage for existing enrollees. The proposed rule would also require Get Covered New Jersey to alter systems and processes to halt future enrollment for DACA recipients. This proposed rule will also require Get Covered New Jersey to abruptly reverse messaging and increase expenditures related to customer outreach and education, change call center scripts, modify website language, and re-train call center workers and consumer assisters to address this mid-year change in policy.

While the Department encourages CMS to abandon this proposed policy permanently, if the policy is adopted it should be delayed until at least plan year 2027 to allow for a full year of coverage for those enrolled and allow time for state Marketplaces to address the change.

Coverage Denials for Failure to Pay Premiums

The Notice proposes, to the extent permitted by state law, to allow issuers, consistent with their terms of coverage, to add past due premiums to the premium a consumer is required to pay to effectuate new coverage. A consumer who fails to pay the past-due premium amounts in addition to the new premium amount will not be able to effectuate the new coverage.

Department Comment: The Department does not support this proposal. This proposal to require past due premium to be paid up as a condition of enrollment would likely result in many consumers being denied enrollment in coverage, particularly those who rely on subsidies or who may face other affordability challenges in sustaining health benefits coverage. The Department is particularly concerned to the extent that the proposed measure could result in coverage denials based on consumers unknowingly owing de minimis amounts in past-due premiums.

The Department previously expressed approval for the additional flexibility, proposed in the 2026 Notice of Benefit and Payment Parameters, with regard to the thresholds at which carriers would be required to trigger a grace period for late premium payments, and continues to express support for that measure, as well as similar measures, that are designed to facilitate continuous enrollment. Moreover, to the extent that enrollees and applicants for coverage owe past due premium resulting from being enrolled in coverage by party agents and brokers acting without the individual's knowledge, as the current rule proposal suggests is an outstanding matter of concern, it would appear to be a manifest injustice for an applicant or enrollee to be denied health benefits coverage resulting from third-party malfeasance.

It is the Department's belief that this proposed measure would result in expanded denials of coverage without facilitating continuous enrollment and without materially improving program integrity.

Standards for Termination of Agents, Brokers and Web-brokers for Cause

HHS proposes to use a preponderance of the evidence standard for termination for cause of exchange agreements of agents, brokers, and web-brokers when they are found to have violated the exchange agreement. HHS seeks comment on this standard and on agent/broker operations.

Department Comment: Regarding HHS's request for comment about agent/broker program integrity issues and potential improvements, New Jersey—like all other State-based Exchanges—does not have the same problems the Federally Facilitated Marketplace (FFM) has experienced with the scale of improper broker activity. However, New Jersey appreciates any best practice guidance, forms, agreements, and documentation that HHS can provide for exchange use, as well as HHS sharing information with all exchanges about brokers de-certified by the FFM and patterns of improper behavior that HHS has detected.

Failure-to-File-Taxes-and-Reconcile Process Changed Back to 1 Year

HHS proposes to return to removing financial help after one-year of failure to reconcile (FTR) status instead of two, and to modify the required notices accordingly.

Department Comment: Regarding HHS's request for comment on aligning state FTR processes with federal FTR processes, the Department does not believe it would be cost beneficial for State-based Exchanges. HHS recognizes that SBEs do not have the resources, or FTR infrastructure, to perform the complex processes needed to protect federal tax information (FTI) in order to align with the federal platform's FTR recheck and direct notice requirements. For the reasons expressed in past comments and as discussed in the Notice (page 12958) regarding state difficulties with trying to incorporate processes that are better carried out by the IRS or the federal government, State-based Exchanges would need to undertake major complex and costly changes to expand the access to FTI in an appropriate manner so that such confidential data could be more fully incorporated into the exchange systems and exchange notices. States and the IRS both wish to avoid expansion of access to FTI. The administrative and other costs for this undertaking would far outweigh its expected gains in accuracy, efficiency, and program integrity for the small percentage of consumers who are found through these processes to have not reconciled. Generic notices can accomplish the same education and provide instruction while protecting consumers' FTI. Alternatively, we would encourage HHS to consider the role of the Internal Revenue Service (IRS) and their usual capabilities in working with FTI and their line-of-sight into in-flight tax filing status. The IRS is provided with a monthly list of enrollees who are receiving APTC (the "EOM file") from the exchanges and could more efficiently implement alternative processes and then inform States which consumers should lose APTCs.

New Income Verification Requirement When Data Sources Indicate Income Is Less Than 100% of FPL

HHS proposes that exchanges would create income data matching inconsistencies for consumers if:

(1) The consumer attested to projected annual household income between 100 percent and 400 percent of the FPL;
(2) the Exchange has data from IRS and SSA that indicates household income is below 100 percent of the FPL;
(3) the Exchange has not assessed or determined the consumer to have income within the Medicaid or CHIP eligibility standard; and
(4) the consumer's attested projected annual household income exceeds the income reflected in the data available from electronic data sources by a reasonable threshold established by the Exchange and approved by HHS.

Department Comment: HHS's concern about consumers over-estimating projected annual income is not a problem in New Jersey because of our expanded Medicaid program for consumers up to 138% FPL.

This is a new verification process HHS would be asking exchanges to create. While the documentation consumers would provide to satisfy the proposed new data matching inconsistency might be the same as for other income inconsistencies, this under-100% inconsistency would have a different verification process to satisfy. Rather than attested income too low, it would be for attested income that is too high. Creating a new verification process and data inconsistency within exchange systems would require significant administrative costs and time to implement. For states where this program integrity issue is not relevant because there is no incentive to inflate income in order to be eligible for health coverage (where Medicaid has been expanded for adults), exchanges should be given the flexibility not to implement this proposed new DMI, especially if costs appear to outweigh the accuracy, efficiency, and program integrity benefits of the proposed new verification process.

Additionally, as set forth in the Notice (page 12963-4), a federal court has previously found that lower income consumers may have a greater administrative burden in obtaining and submitting documentation due to part-time or hourly positions, multiple jobs throughout the year, and/or working in cash industries such as food service where tips may be the larger part of their income and documentation from employers may be harder to obtain.

Annual Eligibility Redetermination – Remove Bronze to Silver Crosswalk

HHS proposes to remove the "bronze to silver crosswalk policy" that allows Exchanges to direct reenrollment for enrollees who are eligible for cost sharing reductions (CSRs) from a bronze QHP to a silver QHP if a silver QHP is available within the same product, with the same provider network, and with a lower or equivalent net premium after the application of APTC.

Department Comment: The Department does not support this proposal. The Department continues to believe that most consumers benefit from the extra cost sharing reductions (with the same provider network) that they might have been unaware they were eligible for. The Department finds that some consumers remain unaware of the benefits of cost sharing reductions and the requirement for a silver level enrollment, contrary to what HHS has noted (Notice page 12974). The Department further finds that only a small number of consumers switch back to bronze plans after being automatically renewed into a silver plan and, in those rare instances, this occurs when these consumers are reporting an income increase making the bronze plan more compelling for them. The Department believes this option to re-enroll consumers into a silver QHP for an upcoming plan year should remain an option, especially for exchanges that do not find their consumers having a negative experience nor being administratively burdened by the current policy.

Premium Payment Threshold

HHS is removing the new premium payment threshold options it recently added to the regulations (gross premium percentage-based threshold, and fixed-dollar premium payment threshold of $10 or less) for program integrity purposes.

Department Comment: The Department does not support this change. The Department previously expressed approval for the additional flexibility, proposed in the 2026 Notice of Benefit and Payment Parameters, with regard to premium payment thresholds, and continues to express support for that measure, as well as similar measures, that are designed to facilitate continuous enrollment. It is the Department's belief that this proposed measure would result in additional disenrollments from coverage based on de minimis payment delinquencies without materially improving program integrity.

Remove Monthly Special Enrollment Period for Consumers with Projected Household Income at or Below 150% of the Federal Poverty Level

HHS proposes to repeal the monthly Special Enrollment Period (SEP) for APTC-eligible qualified individuals with a projected annual household income at or below 150 percent of the FPL on the basis of adverse selection and fraud prevention purposes.

Department Comment: The Department does not support this proposal. New Jersey has adopted this special enrollment period, including for those up to 200 percent of FPL, which is contrary to HHS's statement that it does not believe any SBE has offered the 150 percent FPL SEP (Notice p. 13016). With respect to the population up to 150 percent of FPL, Get Covered New Jersey had approximately 13,000 enrollees utilize this SEP in 2023 and over 35,000 enrollees in 2024. Including those up to 200 percent of FPL increases these numbers to approximately 29,000 in 2023 and over 63,000 in 2024. This low-income SEP has helped numerous individuals overcome challenges enrolling in health coverage. While federal law may specify SEPs that the federal government is required to provide for, it does not and should not preclude states from establishing additional SEPs.

The Department agrees with HHS that states are the primary insurance regulators and are in a better position to know their market and therefore find appropriate solutions to optimize competition, sustain a balanced risk pool, protect the integrity of the marketplace, and effectively expand access to coverage.

The proposal represents a reversal of years of deference to state authority. The Department believes that federally-mandated limits on the use of SEPs restrict the ability of states to implement policies designed to ensure all residents of the state are enrolled in coverage appropriate to and consistent with their needs. The Department has long supported the position that states should be afforded the maximums flexibility possible to implement State-based Exchanges in the ways that make sense to the particular characteristics and needs of each state. Therefore, New Jersey supports flexibility for states in establishing appropriate SEPs for its individual coverage markets (including off-exchange coverage).

As mentioned above, New Jersey has not experienced the program integrity issues the FFM has experienced and has found that this SEP can help bridge the transfer of prior Medicaid enrollees into the Exchange. New Jersey has not found adverse selection effects from this SEP due to consumers being disincentivized to enroll and to maintain enrollment.

Pre-enrollment Verification for Special Enrollment Period

HHS proposes to require that Exchanges conduct SEP verification for at least 75 percent of new enrollments (based on current volume).

Department Comment: The Department does not support this proposal. Contrary to the proposal, SEP verification does not encourage continuous enrollment (Notice page 12984). Instead, having to obtain and verify documents before a consumer can enroll blocks enrollment and is unrelated to whether a consumer maintains continuous coverage later. In general, healthier enrollees who have to navigate administrative barriers are less motivated to follow up and complete processes than sicker individuals. Therefore, this proposal will negatively impact the risk pool. In addition, this proposed SEP verification requirement will add to the administrative burden and cost of the Notice on exchanges. Exchanges will need time to add staffing and upgrade systems to streamline additional verification processes. The Department requests HHS to provide flexibility on the percentage of SEP verification. In the alternative, the Department requests HHS delay the effective date of this proposed change to allow for additional implementation time for exchange operation upgrades in order to create a smoother consumer enrollment process for new consumers applying outside of the OEP who would be subject to the proposed requirements.

Prohibition on Coverage of Sex-trait Modification as an EHB

HHS proposes to prohibit states from including gender-affirming care, referred to as "sex trait modification" in the proposal, as an essential health benefit (EHB). EHBs are subject to prohibitions against annual and lifetime dollar limits, protections related to cost sharing, and various other protections and special requirements. Disallowing gender-affirming care as an EHB would remove these protections.

Department Comment: Under P.L.2017, c.176, individual health benefits plans in New Jersey are prohibited from discriminating in the provision of coverage on the basis of gender identity or expression; this prohibition extends to denying access to care and services for individuals who are transgender when the care or services are not specific to gender transition, including hormone therapies, hysterectomy, mastectomy, and vocal training, as well as sex-specific care and services that can be accessed by an individual undergoing gender transition.

Therefore, the Department opposes any measures that limit state flexibility in ensuring that health benefits coverage requirements are designed in a way that meets the coverage needs of all persons present in the State. Governor Murphy issued Executive Order 326 protecting gender-affirming health care in New Jersey and the Department issued Bulletin 23-05 directing carriers to comply with State and Federal laws against discrimination on the basis of a covered person's or prospective covered person's gender identity or gender expression or on the basis that the covered person or

prospective covered person is a transgender person. The Department has directed carriers to ensure coverage is available to a transgender person on the same terms as other covered persons, including that carrier ensure that there is an adequate network of health care providers that will provide all covered services to the covered person regardless of the covered person's gender identity or gender expression, or whether the covered person is a transgender person.

Finally, the Department finds that preventing carriers from covering treatment for people with gender dysphoria as EHB is contrary to the requirement that EHBs be defined in a way that protects individuals from discriminatory benefit design. It is also inconsistent with existing laws and policies, including Section 1557 of the ACA, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act—laws that courts have interpreted to prohibit discrimination against people with gender dysphoria.

Premium Adjustment Percentage

HHS proposes revising the premium adjustment percentage index to use average per enrollee private health insurance premiums instead of employer-sponsored insurance premiums for the purposes of calculating the premium adjustment percentage for PY 2026 and beyond. The annual premium adjustment percentage sets the rate of change for several parameters detailed in the ACA, including the annual limitation on cost sharing, the reduced annual limitations on cost sharing, the required contribution percentage used to determine eligibility for certain exemptions, and employer shared responsibility payments.

Department Comment: The Department notes the proposal projects that the shift in the percentage will result in increased premiums and, consequently, decreased eligibility for fully subsidized plans. The change may also result in higher rates of people going uninsured or enrolling in catastrophic coverage, as well as reduced utilization across some markets, which may further result in higher federal and state uncompensated care costs and negative public health outcomes. Because it is likely to result in increased rates of uninsurance and underinsurance, and is anticipated to make health benefits coverage unaffordable for individuals relying on fully-subsidized plans, the Department opposes this proposal.

Levels of Coverage (Actuarial Value)

HHS proposes, beginning in PY 2026, to change the de minimis ranges for individual and small group market plans subject to the Actuarial Value requirements under the EHB package, with alternate values proposed for expanded bronze plans. HHS also proposes to remove the de minimis range for individual market silver qualifying health plans. The proposal indicates this will allow issuers to design plans with a lower AV than is possible under the current de minimis ranges, which will reduce the generosity in health plan coverage for out-of-pocket costs, but will purportedly reduce overall premiums, increase competition within the market, improve the risk pool, and afford consumers additional options when selecting plans. HHS proposed that providing issuers with greater flexibility to increase cost-sharing for consumers will reduce premiums, improve the risk pool, and reduce the risk that issuers will exit the market. HHS estimates that gross premiums

would decrease 1%, on average, as a result of this change. HHS also acknowledges that widening the de minimis range for on-Marketplace silver plans will reduce Advanced Premium Tax Credits (APTC) for consumers, and, thus, increase net premiums. This is because APTCs are based on the premiums for the second lowest cost silver plan in the market, and plans with lower actuarial values generally have lower premiums.

Department Comment: The Department opposes this measure. The proposed change will result in higher costs for the vast majority of Marketplace enrollees, due to the reduction in APTCs. CMS's own analysis acknowledges that the expanded de minimis ranges will effectively transfer costs from the government to consumers, by reducing APTCs in plan year 2026 by $1.22 billion, growing to $1.4 billion in plan year 2029.

Any reduction in premiums for unsubsidized enrollees will result in more enrollees receiving less generous coverage and exposing enrollees to higher deductibles and other cost sharing. New Jersey has implemented a reinsurance program under a section 1332 waiver, which benefits unsubsidized enrollees in New Jersey's individual market.

Increasing the de minimis range will not improve the Marketplace risk pool. In fact, the opposite is likely to occur. This proposed change will decrease premiums for a small number of unsubsidized enrollees, but it will increase premiums for comparable coverage for the much larger number of subsidized enrollees. The evidence is clear: those most likely to drop their insurance due to an increase in premiums are healthy individuals; sicker individuals are more willing to tolerate higher premiums because they need the coverage. This proposed change will thus lead to a smaller, sicker Marketplace risk pool.

The proposal suggests that the proposed changes to de minimis range are also necessary because carriers threaten to leave the market without additional flexibility. However, New Jersey has experienced an increase in competition in the market without this proposed flexibility. There is no evidence that issuers will withdraw from the marketplaces. For these reasons, we urge HHS not to finalize the proposal to widen de minimis ranges.

Income Verification

HHS proposes two policies that will generate more paperwork related to income verification, especially for low-income people: generating a "data matching issue" ("DMI") when IRS data show income below 100% FPL, and generating a DMI in the absence of IRS data.

HHS proposes to remove the authority for Exchanges to accept an applicant's or enrollee's self-attestation of projected annual household income when the Exchange requests tax return data from the IRS to verify attested projected annual household income, but the IRS confirms there is no such tax return data available (no tax return data due to failure to file, change in household [birth. marriage, divorce], name change, or other demographic mismatches). States can use approved alternative data sources for income verification.

Department Comment: These changes will make it more burdensome and less efficient for low-income people and those with variable incomes or family circumstances to receive benefits to which they are entitled. The Department believes this will negatively impact the risk pool in the individual market. The proposals will place a significant administrative burden on people and on Get Covered New Jersey. The proposals will generate significantly more income DMIs, requiring individuals and the Marketplace to work through additional paperwork in order for those consumers to access health insurance.

This administrative burden will deter enrollment of younger and healthier enrollees and will likely cause adverse selection. Young healthy enrollees are less likely to jump through these administrative hoops than a person in dire need of health care due to chronic or acute illness. Deterring these younger and healthier people from enrolling will undermine the goal of the proposed rule to improve risk pools.

Annual Eligibility Redetermination - $5 minimum premium

HHS is proposing that if an enrollee does not submit an application for an updated eligibility determination on or before the last day on which a plan selection must be made for coverage effective January 1, and the enrollee's portion of the premium for a policy after the application of advance payments of the premium tax credit through the Exchange's annual redetermination process would be zero dollars, the Exchange must decrease the amount of the advance payment applied to the policy such that the remaining monthly premium owed for the policy equals $5.

Department Comment: The Department does not believe that this proposed change is permissible under the ACA. Section 36B of the Internal Revenue Code, as added by the ACA, prohibits such a rule as it defines how a premium tax credit may be calculated. Once an individual has been determined eligible under section 1411, the federal government "shall make" payments in the amount "allowed under section 36B," as required under section 1412. In other words, the statute makes payment of the full amount mandatory.

This proposal is arbitrary in that it requires Marketplaces to reduce APTC so that the consumer owes a premium of $5 even when that is not the appropriate calculation under the ACA. Section 1412 clearly forecloses this outcome. The Department does not believe that the ACA confers authority to make the advance determination of eligibility but then pay less than the amount dictated by the eligibility determination.

In addition to the above concerns, the Department is concerned that the proposed changes will require significant expenditure and burden on Get Covered New Jersey, requiring us to expend technical resources to charge consumers an arbitrary amount established by this proposed rule. Further, with the proposed shortened OEP under this proposed rule, it will be incredibly challenging to address the consumer confusion that will result from this proposed rule.

Conclusion

The New Jersey Department of Banking and Insurance supports policies that will encourage state innovation and flexibility to meet the unique needs of the state and its market while also helping New Jersey residents obtain quality, affordable health insurance. Thank you for considering these comments on proposals that will directly impact New Jersey residents, New Jersey's individual market, and the continued operations of New Jersey's State-based Exchange.

Sincerely,

Justin Zimmerman
Commissioner